Office Use Only
- ☐ Referral Received: __/__/____
- ☐ Previous Client
- ☐ Prev. Discharge Date __/__/____
- ☐ Discharge Reason
- ☐ Standard Process
- ☐ Fastracked

Children and Youth Services
Referral Form

Children who meet the eligibility criteria for services will be accepted for the therapy service program funded by Disability Services Commission

Personal Details

Child's First Name(s):			
Child's Family Name:			
Date of Birth:		Child's Sex: *(please circle)*	**(F)** **(M)**
Home Address:			
			Postcode:
Country of Birth:			
Australian Residency Status:	☐Permanent	☐Temporary	☐Other
*If you have ticked **Other** please give details:*			

What is the main language spoken in the child's home?	

Does the child require interpreter services?		
☐ No	☐ Yes (for spoken language other than English)	☐ Yes (for non-spoken communication, Makaton etc)

What is the child's *most* effective method of communication?	**✓ Tick**
Uses speech to say what they want	☐
Uses sign language to say what they want	☐
Uses a communication device to say what they want (e.g. Canon Communicator, Compic)	☐
Little or no effective communication	☐
Child under 5 years old	☐

Is the child of:	**✓ Tick ONE only**
Aboriginal but not Torres Strait Islander origin	☐
Torres Strait Islander but not Aboriginal origin	☐
Both Aboriginal and Torres Strait Islander origin	☐
Neither Aboriginal nor Torres Strait Islander origin	☐

Does the child:	**✓ Tick ONE only**
Live alone	☐
Live with Family	☐
Live with others *If **Yes**, please give us details of who the child lives with:*	☐

Residential setting: Please tick one (1) only which best describes the child's living arrangements for 4 or more days per week:	
Private residence	☐
Residence within an Aboriginal/Torres Strait Islander community	☐
Supported accommodation facility domestic scale *–group homes (i.e., 24-hour supervision/care and less than 7 people)*	☐
Supported accommodation facility *– hostels (i.e.,7 or more people and 24-hour supervision/care)*	☐
Short term crisis accommodation or transitional accommodation	☐
Other: *Please give details of **other** accommodation arrangements*	☐

 **Compensation: – *if applicable***	**✓ Tick**
Are you applying for compensation for the child?	☐ Yes ☐ No
Are you currently receiving compensation on behalf of the child?	☐ Yes ☐ No
If ***Yes*** to either of the above, please provide the Solicitor's name, address and contact details:	

ONLY ANSWER THE FOLLOWING QUESTION IF THE CHILD IS *15 YEARS OF AGE OR OLDER.*			
Is the child:			
☐Employed	☐Unemployed	☐Not looking for work	☐Still at school

ONLY ANSWER THE FOLLOWING QUESTION IF THE CHILD IS *16 YEARS OF AGE OR OLDER.*	
What is the child's main source of income?	
Disability Support Pension (*If ticked please provide the child's Centrelink No)* _____	☐
Other pension or benefit *(not superannuation)*	☐
Receiving compensation *(If ticked fill in Compensation Section on page 2)*	☐
Other *(superannuation, investments, etc)*	☐
Paid employment	☐
Nil income from any source	☐

Disability

- *Please show the child's main disability by ticking one (1) box only against Primary Disability.*
- *Tick all other significant disabilities in the column headed Other Significant.*

TYPE OF DISABILITY	Primary Disability ✓ *Tick one (1) box only*	Other Significant ✓ *Tick as many as apply*
1. Cognitive or Learning Disability		
Acquired brain injury [1]	☐	☐
Specific learning *(other than Intellectual)* [2]	☐	☐
Attention Deficit Disorder [2.1]	☐	☐
2. Intellectual Disability		
Developmental delay *(applies to 0-5 year olds only)* [4]	☐	☐
Intellectual Disability *(including Down Syndrome)* [5]	☐	☐
3. Autism Spectrum Disorder		
Asperger's Syndrome [3]	☐	☐
Autism [3]	☐	☐
PDD [3]	☐	☐
4. Neurological Disability		
Multiple Sclerosis [6]	☐	☐
Epilepsy [7]	☐	☐
OTHER Neurological [7] (please specify): _____	☐	☐
5. Physical Disability		
Cerebral Palsy [8]	☐	☐
Motor Neurone Disease [9]	☐	☐
Muscular Dystrophy [10]	☐	☐
Para/Quadri/Tetra Hemiplegia [11]	☐	☐
Spina Bifida [12]	☐	☐
OTHER Physical [13] (please specify): _____	☐	☐
6. Sensory Disability		
Deafblind *(dual sensory)* [15]	☐	☐
Blind/Vision *(sensory)* [16]	☐	☐
Deaf/Hearing *(sensory)* [17]	☐	☐
Non Verbal/Speech Impairment [18]	☐	☐
7. Psychiatric [14] (please specify): _____	☐	☐
8. Other Disability [19] (please specify): _____	☐	☐

Care and Support Needs

ANSWER THE FOLLOWING QUESTIONS FOR CHILDREN OF ***ALL AGES***	
 Has the child had, or going to have, surgery or specialist medical intervention? *(If* **Yes** *please give details)*	☐Yes ☐No
 Does the child need special straps for the bus or car? *(If* **Yes** *please give details)*	☐Yes ☐No
 Does the child need equipment or aid for mobility, communication, and/or self care? *(If* **Yes** *please give details)*	☐Yes ☐No
 Does the child often cough, choke or gag during mealtimes? *(If* **Yes** *please give details)*	☐Yes ☐No
 Do you have any other concerns about your child's health? *(If* **Yes** *please give details)*	☐Yes ☐No

Tick one (1) box in each area that <u>best</u> describes the child's need for help or supervision.

- eg if your child always needs help with dressing, but is able to perform effectively in other areas of self care, you would select "Always needs help or supervision", which is the highest level of need for that area.

	Always needs help or supervision	Sometimes needs help or supervision	Does not need help <u>but uses</u> aids or equipment	Does not need help and <u>does not use</u> aids or equipment
Self Care: • Washing • Dressing • Eating • Toileting	☐	☐	☐	☐
Mobility: • Moving around at home and/or away from home. Includes: - Walking - Getting in/out of bed or a chair - Using public transport	☐	☐	☐	☐
Communication: • Making themselves understood • Understanding others	☐	☐	☐	☐
Interpersonal Relationships: • Can make and keep friends • Behaves in acceptable ways • Copes with feelings	☐	☐	☐	☐

ONLY ANSWER THE FOLLOWING QUESTION IF THE CHILD WILL BE *5 YEARS OF AGE OR OLDER BEFORE JULY 1ST.*

	Always needs help or supervision	Sometimes needs help or supervision	Does not need help but uses aids or equipment	Does not need help and does not use aids or equipment
Learning: • Understanding new ideas • Remembering • Problem solving • Making decisions • Paying attention • Doing single or multiple tasks • Carrying out daily routines	☐	☐	☐	☐
Education: • Tasks required at school	☐	☐	☐	☐
Community Participation: • Recreation and leisure • Handling money • Shopping	☐	☐	☐	☐

ONLY ANSWER THE FOLLOWING QUESTION IF THE CHILD WILL BE *15 YEARS OF AGE OR OLDER BEFORE JULY 1ST.*

	Always needs help or supervision	Sometimes needs help or supervision	Does not need help but uses aids or equipment	Does not need help and does not use aids or equipment
Domestic Life • Making meals • Cleaning • Cooking • Shopping	☐	☐	☐	☐
Work skills • Work experience • Part time work • Voluntary work experience • School based work skills training programs	☐	☐	☐	☐
Health Care • exercising muscles and limbs • taking medication • dressing wounds	☐	☐	☐	☐

Community Participation

What is the child's usual day activity? *(you may tick more than one box):*		
☐ No formal day activity	☐ Day Care	☐ Child Care
☐ Kindergarten	☐ Pre-school	☐ Home School
☐ Education Support Centre	☐ Education Support School	☐ School

School Information		
Name of School/Centre(s):		
Address:		
Suburb:		Postcode:
Telephone Number:		
 Teacher's Name:		
Current School Year:		
Is the child changing schools/child care in the next 12 months: ☐ Yes ☐ No		
If **Yes**, do you know what date:		
Name of School/Centre(s) your child will attend:		

Services and Agencies Previously and Currently Involved in Care of the Child	
Princess Margaret Hospital:	☐ Yes ☐ No
Other Hospital *(please specify):*	☐ Yes ☐ No
Child Development Centre *(please specify)*:	☐ Yes ☐ No
Please describe Therapy/services received:	
Are you currently waitlisted with any other service providers? *(e.g. Autism Association, The Centre for Cerebral Palsy, Disability Services Commission etc)*	☐ Yes *(please specify)* ☐ No
Other Agencies currently involved in providing services to your child (*e.g. Local Area Coordinator, Autism Association, Resource Unit for Children with Special Needs, Department for Community Development, etc*):	☐ Yes *(please specify)* ☐ No
Family Doctor/GP:	Name: Location:
Specialist Doctor:	Name: Location:
Specialist Doctor:	Name: Location:

Parent/Carer/Guardian Information

A carer is someone who provides a significant amount of care to the child, generally for a period of 6 months or longer. Care can be provided formally or informally.

A formal carer is a paid or unpaid person arranged to provide care by a service provider. Usually a formal carer is unrelated to the child.

An informal carer includes people who receive a pension or benefit for their caring role including a host family, foster family, friends and family members.

Primary Carer (tick ONE only): ☐ **Informal** ☐ **Formal**			
First Name:			
Family Name:			
Address (if different from child):			
Suburb:			Postcode:
Home Phone:		Work Phone:	
Mobile:		Email:	
Main Language spoken at home:		**Interpreter Required?**	☐ Yes ☐ No

Secondary Carer (tick ONE only): ☐ **Informal** ☐ **Formal**			
First Name:			
Family Name:			
Address (if different from child):			
Suburb:			Postcode:
Home Phone:		Work Phone:	
Mobile:		Email:	
Main Language spoken at home:		**Interpreter Required?**	☐ Yes ☐ No

You may add other carers involved with the child on a separate sheet of paper

Informal Carer Details (carer should be listed on previous page)	
Does the child have an **informal carer**, such as a family member, friend or neighbour, who provides care & assistance on a regular basis?	☐ Yes ☐ No

IF THE CHILD DOES NOT HAVE AN INFORMAL CARER SKIP THE REST OF THIS PAGE			
What is the relationship of the primary INFORMAL carer to this child?			
☐ Mother	☐ Other female relative	☐ Female friend/neighbour	
☐ Father	☐ Other male relative	☐ Male friend/neighbour	
Does the **main** carer live in the same household as the child?		☐ Yes ☐ No	
If the child is under 16, does the carer receive Carer's Allowance from Centrelink for the child:		☐ Yes ☐ No	
If **YES** please provide the child's Centrelink Number:			
What age group does the Main Carer fit into?			
☐ 15-24 years	☐ 25-44 years	☐ 45-64 years	☐ 65 years and over
Does the carer assist the child in the area(s) of self-care, mobility or communication?		☐ Yes ☐ No	

Parent/Guardian Consent

Child's Name: _____
(First Name) **(Family Name)**

Parent/Guardian Name(s): _____
(First Name) **(Family Name)**

I / We give Therapy Focus consent to access reports and information regarding the child so Therapy Focus can assess if he/she is eligible to receive services.
These may include:

- Psychological Reports
- Medical Reports
- Therapy Reports
- Educational Reports
- Other Reports

I / We give consent for Therapy Focus to work with the child and for:		
• My/our child to sometimes receive services from a student working under a Therapy Focus staff member		☐Yes ☐No
• Therapy Focus to share information about the child with:		
	- School authority	☐Yes ☐No
	- Medical or Therapy personnel	☐Yes ☐No
	- Other (please specify)	☐Yes ☐No
• Therapy Focus to photograph or video the therapy session/s provided to the child for use in therapy		☐Yes ☐No

I/We understand this consent will stay in place while the child is receiving services from Therapy Focus. I/we agree to advise Therapy Focus about any changes that may affect this consent.

Therapy Focus is bound by the *Privacy Act 1988* and undertakes to adhere to the National Privacy Principles.

Please note that Therapy Focus is required to release information about service users to the Disability Services Commission and then without identifying you, to the Australian Institute of Health and Welfare, to enable statistics about disability services and their clients to be compiled. The information will be kept confidential. This information is for statistical purposes only and will not be used to affect your entitlements or your access to services. As a user of CSTDA-funded services you have the right to access your own files and to update or correct information included in the ACDC collection.

SIGNED: _____ **DATE:** _____

Please send in any reports or information that describe the child's needs, to assist us to check the child's eligibility to access services provided by Therapy Focus, funded by Disability Services Commission.

Person Completing This Form

Name: _____

Relationship to the child: _____

Contact Phone Number: _____

Best time to contact (days/times): _____

Postal Address: _____

Email Address: _____

Please add in the names of anyone you would like to be contacted about this request, e.g., the school principal, the child's teacher, etc.

Name: _____

Relationship to Child: _____

Contact Phone Number: _____

Best time to contact (days/times): _____

Postal Address (if known): _____

Email Address (if known): _____

Thank you for completing this Referral Form. Contact will usually be made with the person referring the child within two weeks of the form being received. However, on occasions a delay may occur. Please feel free to ring our Central Office on the telephone number below if you have not heard from us.

Please return completed Referral Form to:

Therapy Focus Inc

PO Box 20
BENTLEY WA 6982
Phone: (08) 9478 9500 Fax: (08) 9451 5480
Email: enquiries@therapyfocus.org.au

Checklist:

☐ All sections of this form are completed

☐ Form is signed & dated

☐ Reports are attached